MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0085

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. #

1. PROCESSING TYPE

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

5 DATE OF BIRTH

6. SEX M ☐ F ☐

7 BILLING PROVIDER TELEPHONE NO. ( )

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE:

9. BILING PROVIDER NO.

10. DX: PRIMARY

11. DX: SECONDARY

12. START DATE OF SOI:

13. FIRST DATE Rx

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
					TOTAL CHARGE	21

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22 _____ DATE

23. _____ REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE